

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a State Licensure survey conducted in your facility on 11/2/10. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The census at the time of the survey was one. One resident file was reviewed and two employee files were reviewed. One discharged resident file was reviewed.</p> <p>The following regulatory deficiencies were identified:</p>	H 000			
H 011	<p>Director Duties-Needs Assessment</p> <p>NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 2. Ensure that the needs of each resident of the home are assessed upon admission of the resident to the home, and that the assessment is updated as the needs of the resident change.</p> <p>This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 1 residents was assessed upon admission for the functional needs as well as supervision, personal care, and</p>	H 011			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 011	Continued From page 1 dietary needs (Resident #1).	H 011			
H 017	Director Duties-Protective Supervision NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 3. Ensure that the residents of the home: (b) Receive: (3) Protective supervision and adequate services to maintain and enhance their physical, mental and emotional well-being. This Regulation is not met as evidenced by: Based on record review, observation and interview on 11/2/10, the director failed to ensure that 1 of 1 residents received adequate services to maintain and enhance their physical, mental and emotional well-being (Resident #1 was found at 9:00 AM, with a double diaper on, contained within a hospital bed with wet clothes and sheets. The head and foot of the bed, as well as the side rails were raised so that the resident could not get out of bed. The caregiver reported that he was trying to prevent the resident from falling out of bed. He reported the hospice nurse told him to use a double diaper.	H 017			
H 030	Safety&Sanitation-Home Clean; Hazard Free NAC 449.15525 Requirements for safety and sanitation of facility. (NRS 449.249) 1. The interior and exterior of a home must be clean and free of hazards and offensive odors. This Regulation is not met as evidenced by: Based on observation on 11/2/10, the interior and	H 030			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 030	Continued From page 2 exterior of the home was not clean and free of hazards. The wooden ramp from the patio door transitioned to an uneven wooden walkway due to rotting supports. There was a concrete ramp from the sunken wooden walkway to the pavers that created a tripping hazard. From the wooden walkway, there were wooden steps up to a platform around a non-functioning uncovered hot tub. Examination of the steps and platform revealed numerous rusty nails protruding out of the wood. The uncovered hot tub contained stagnant brown water and trash. This presents a drowning hazard and a insect breeding area for Resident #1 who is an ambulatory resident with severe cognitive impairment.	H 030			
H 031	Safety & Sanitation -Furnishings NAC 449.15525 Requirements for safety and sanitation of facility. (NRS 449.249) 2. A home must contain: (a) Appropriate and well-maintained furnishings; This Regulation is not met as evidenced by: Based on observations on 11/2/10, the home did not contain appropriate and well-maintained furnishings. The recliner chair in Resident #1's room was covered in stained soiled fabric with worn uneven batting inside. The chairs used outside for Resident #1 were covered in stained fabric.	H 031			
H 034	Safety&Sanitation-Food Preparation	H 034			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 034	<p>Continued From page 3</p> <p>NAC 449.15525 Requirements for safety and sanitation of facility. (NRS 449.249)</p> <p>2. A home must contain:</p> <p>(d) Equipment that is sufficiently clean and adequate for the preparation, service and storage of food;</p> <p>This Regulation is not met as evidenced by: Based on record review and interview on 11/2/10, the facility failed to ensure that equipment was clean and sanitary for the preparation, service and storage of food.</p> <p>For example, the refrigerator was broken so that the internal elements were protruding into the cooling compartment. The bottom drawer was broken decreasing the space for storage of food items requiring cold storage. Cooked rice was found cold in the rice cooker. Hard cooked eggs were sitting in warm water on the stove top, some of which had cracked open exposing the cooked yolk and white to the tepid water. Room temperature, raw egg yolks were found in a bowl sitting in the microwave. Outside under a canvas awning, there were two stoves hooked up to propane tanks used by the owner to prepare meals. These stoves were covered in dust and food debris. A cold pot of cooked chicken was found on top of one of these stoves in liquid. The facility owner reported she had barbecued it yesterday. She stated she had no room to store the chicken in the refrigerator. There were three areas of the kitchen counter where the grout was missing in large chunks.</p>	H 034			
H 041	<p>Records of Residents-Maintain file 5 years</p> <p>NAC 449.15527 Agreement between operator of home and resident concerning rates;</p>	H 041			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 044	Continued From page 5 examination conducted by a physician for 1 of 1 residents (Resident #1).	H 044			
H 055	Tuberculosis-Residents NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120) 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not	H 055			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 055	<p>Continued From page 6</p> <p>a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner.</p> <p>(c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.</p> <p>3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis.</p> <p>4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and</p>	H 055			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 055	<p>Continued From page 7</p> <p>Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis.</p> <p>5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFIB smears which were collected on separate days.</p> <p>6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200.</p> <p>7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive</p>	H 055			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 060	Continued From page 9 10. An ultimate user or any person designated by the ultimate user pursuant to a written agreement. This Regulation is not met as evidenced by: Based on record review on 11/2/10, the facility did not obtain an ultimate user agreement authorizing the facility to administer medications to 1 of 1 residents (Resident #1).	H 060			
H 065	Employee Background Check Requirements NRS 449.179 Initial and periodic investigations of criminal history of employee or independent contractor of certain agency, facility or home. 1. Except as otherwise provided in subsection 2, within 10 days after hiring an employee or entering into a contract with an independent contractor, the administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing, a residential facility for groups or a home for individual residential care shall: (a) Obtain a written statement from the employee or independent contractor stating whether he or she has been convicted of any crime listed in NRS 449.188. (b) Obtain an oral and written confirmation of the information contained in the written statement obtained pursuant to paragraph (a);	H 065			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 065	Continued From page 10 (c) Obtain from the employee or independent contractor two sets of fingerprints and a written authorization to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and (d) Submit to the Central Repository for Nevada Records of Criminal History the fingerprints obtained pursuant to paragraph (c). 2. The administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing, a residential facility for groups or a home for individual residential care is not required to obtain the information described in subsection 1 from an employee or independent contractor who provides proof that an investigation of his or her criminal history has been conducted by the Central Repository for Nevada Records of Criminal History within the immediately preceding 6 months and the investigation did not indicate that the employee or independent contractor had been convicted of any crime set forth in NRS 449.188. 3. The administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing, a residential facility for groups or a home for individual residential care shall ensure that the criminal history of each employee or independent contractor who works at the agency or facility is investigated at least once every 5 years. The administrator or person shall: (a) If the agency, facility or home does not have the fingerprints of the employee or independent contractor on file, obtain two sets of fingerprints	H 065			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3480HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2010
NAME OF PROVIDER OR SUPPLIER HOLY ANGEL HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OPIO STREET SPARKS, NV 89431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 065	Continued From page 11 from the employee or independent contractor; (b) Obtain written authorization from the employee or independent contractor to forward the fingerprints on file or obtained pursuant to paragraph (a) to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and (c) Submit the fingerprints to the Central Repository for Nevada Records of Criminal History. 4. Upon receiving fingerprints submitted pursuant to this section, the Central Repository for Nevada Records of Criminal History shall determine whether the employee or independent contractor has been convicted of a crime listed in NRS 449.188 and immediately inform the Health Division and the administrator of, or the person licensed to operate, the agency, facility or home at which the person works whether the employee or independent contractor has been convicted of such a crime. 5. The Central Repository for Nevada Records of Criminal History may impose a fee upon an agency, a facility or a home that submits fingerprints pursuant to this section for the reasonable cost of the investigation. The agency, facility or home may recover from the employee or independent contractor not more than one-half of the fee imposed by the Central Repository. If the agency, facility or home requires the employee or independent contractor to pay for any part of the fee imposed by the Central Repository, it shall allow the employee or independent contractor to pay the amount through periodic payments.	H 065			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.